



Kentucky Meaningful Use Collaborative Workgroup
Health Information Exchange Objective 5; MU Guidance

Health Information Exchange Guidance: Objective 5 Modified Stage 2 Meaningful Use in 2015-2017

On October 6, 2015, the Centers for Medicare & Medicaid Services (CMS) released the Finalized Stage 3 and Modifications to Meaningful Use (MU) in 2015 through 2017 Rule. The Kentucky Health Information Exchange (KHIE) helps facilitate MU for public health reporting as well as facilitating the Health Information Exchange (HIE) objective, (previously named 'transitions of care/summary of care'), in the Modifications to MU in 2015-2017; objective 5. The Final Rule provides more flexibility, namely around the electronic transmission method for the HIE measure, which states, the provider that transitions or refers their patient to another setting of care or provider of care must—(1) use their certified electronic health record technology (CEHRT) to create a summary of care record; and (2) electronically transmit such summary to a receiving provider for more than 10 percent of transitions of care and referrals. Per the Final Rule, CMS has expanded the mechanisms by which a provider can send and receive a summary of care record, or a consolidated continuity of care document (C-CDA).

The following items can facilitate providers in meeting the HIE objective and should be analyzed when working to meet the measure.

1. **Referral Partners:** As a starting point, it is imperative to first examine your referral partners. Focus on the referral partners that have the highest volume of transitions of care that you need to meet the 10% threshold in MU objective 5; often times this can be one or two 'heavy-hitting' referral partners.
 - a. You must determine *if* your referral partners can successfully receive summary of care documents by any electronic mechanism.
2. **Electronic Transmission Method:** We encourage providers to seek the most expedient means to meet the HIE objective. EHR vendors may offer variable methods to send transitions of care/summary of care documents.
 - a. First check with your vendor to determine if they offer you an electronic mechanism to send C-CDAs to your referral community. This may include, for example, Direct secure messaging, among other methods that can be used in tandem to achieve the HIE measure.
3. **Summary of Care Record (C-CDA) Technology:** You will need to ensure your messages are being received successfully from your referral partners. You must test to confirm C-CDAs are being received successfully, verify the C-CDA that is being received is complete/comprehensive and correct and verify the summary of care record is being displayed properly within the EHR. The



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required fields for the summary of care documents used to meet this objective include the following information if the provider knows it:

- a. Patient name
- b. Referring or transitioning provider's name and office contact information (EP only)
- c. Procedures
- d. Encounter diagnosis
- e. Immunizations
- f. Laboratory test results
- g. Vital signs (height, weight, blood pressure, BMI)
- h. Smoking status
- i. Functional status, including activities of daily living, cognitive and disability status
- j. Demographic information (preferred language, sex, race, ethnicity, date of birth)
- k. Care plan field, including goals and instructions
- l. Care team including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider
- m. Discharge instructions (Hospital only)
- n. Reason for referral (EP only)
- o. Current problem list (providers may also include historical problems at their discretion)*
- p. Current medication list*
- q. Current medication allergy list*
 - i. *An EP or hospital must verify these three fields are not blank and include the most recent information known by the EP or hospital as of the time of generating the summary of care document.

4. **Direct Secure Messaging:** Most ambulatory EHR vendors have partnered with a Health Information Service Provider (HISP) in order to transmit C-CDAs electronically via Direct Secure Messaging. Whereas all 2014 certified EHR technologies have Direct secure messaging capabilities embedded within their EHR. If this is available to you, this may be the most expedient means to meet the objective.

- a. First check with your EHR vendor to determine if you have a HISP. You can check that information both with your vendor and through the certified health IT product list (CHPL) website, found at <http://onchpl.force.com/ehrcert?q=chpl>.
 - i. If your vendor has partnered with a HISP, you will need to make sure your EHR is fully LIVE with Direct messaging and the HISP.
 - ii. In order for your referral partners to receive your Direct secure messages; there must be a form of trust between HISPs. You will need to verify your HISP is accredited with the Direct Trust Agent Accreditation Program



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(DTAAP) in order for your messages to flow successfully to distinct HSPs that are also DTAAP HSPs. You can confirm that information both with your EHR vendor and at <https://directtrust.org>.

- iii. You will need to determine what your referral partners' Direct secure email addresses are in order to send messages successfully. In some instances providers have setup a generic Direct email address to receive all referrals.
 1. If you need assistance, KHIE offers a KY Direct Email Catalog, instructions found at <http://khie.ky.gov/tech/pages/dec.aspx>, in which providers can access a database with Direct email addresses, as well as register their own address.
 2. If you need assistance reaching out to your colleagues across KY, you can join a community contact list that KHIE manages. To join the list, please contact, Sue Anderson-Lenz at Sue.Anderson-Lenz@ky.gov.

5. **Workflow Process:**

- a. In order to meet the HIE objective, you must ensure your technology to send summary of care records is enabled as mentioned above and your C-CDA template is complete. Additionally, you must ensure that you understand how to generate a summary of care record using your certified EHR technology, send it on to your referral partners, and receive C-CDAs within your EHR.
- b. It is important to understand how you will respond to inquiries to send summary of care records to your referral community. Additionally, you must also understand how your facility will handle C-CDAs.
- c. Outlining your workflow encourages a seamless referral/transition of care process.
- d. To ensure compliance, maintain a log of your HIE process and the ways in which you have sent summary of care records electronically to your referral community.

6. **Reporting:**

- a. You will need to ensure your EHR vendor can produce an accurate MU report of your numerator and denominator for the HIE objective.
- b. Additionally, any reports that can be used to supplement your EHR MU reports should be maintained.
- c. If you are using multiple electronic means to achieve the 10% threshold, you must retain documentation that entails these methods for audit purposes.



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The transport methods KHIE provides to facilitate the HIE objective include the following:

- Direct/Health Information Service Provider (HISP) services for certified EHR vendors that have not partnered with a HISP
- Direct web-mailboxes to provision for providers who do not have a certified EHR, 'whitespace providers'

If you wish to utilize KHIE services, providers cannot rely on this as means for achieving the HIE objective until you are LIVE with said service; please be mindful that connecting via the aforementioned transports require a unique and separate connection that may be time-consuming and reveal several unknown situations that often require KHIE, participant, and vendor troubleshooting.

If you would like more information about the HIE objective, contact your regional extension center near you, at <http://kentuckyrec.com/> or <http://nekyrhio.org>, if you would like more information about KHIE, you can visit <http://khie.ky.gov>.